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RELATIONSHIP THERAPY AND/OR BEHAVIOR THERAPY.

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SINCE THERE ARE SOME WIDELY PREVALENT MISCONCEPTIONS OF CLIENT-CENTERED COUNSELING, ATTENTION IS CALLED TO WHAT CLIENT-CENTERED COUNSELING IS NOT. CONDITIONS WHICH THE CLIENT-CENTERED VIEW HOLDS ARE NECESSARY AND SUFFICIENT CONDITIONS OF PSYCHOTHERAPY ARE EMPATHIC UNDERSTANDING, UNCONDITIONAL POSITIVE REGARD, AND SELF-CONGRUENCE. THESE ARE COMMON TO ALL APPROACHES TO PSYCHOTHERAPY, AND WHERE THEY ARE ABSENT, POSITIVE CHANGE OR DEVELOPMENT DOES NOT OCCUR. CLIENT-CENTERED GOALS HAVE BEEN DISMISSED AS TOO VAGUE BY BEHAVIOR THERAPISTS. HOWEVER, SPECIFIC GOALS SHOULD BE SEEN AS STEPS TOWARD OR ASPECTS OF A MORE GENERAL GOAL. THE RELATIONSHIP, WHICH IS THE ESSENCE OF CLIENT-CENTERED COUNSELING, IS A NECESSARY CONDITION FOR THERAPEUTIC PERSONALITY CHANGE AND PLAYS AN IMPORTANT ROLE IN BEHAVIOR THERAPY. REINFORCEMENT, CONDITIONING, AND DESENSITIZATION ARE SHOWN TO BE PART OF ANY EFFECTIVE THERAPEUTIC RELATIONSHIP. THE MAIN DIFFERENCE BETWEEN BEHAVIOR AND RELATIONSHIP THEORY IS ONE OF EMPHASIS, AND THE CONCRETENESS OF THE BEHAVIORIST MOVES FROM PSYCHOTHERAPY TOWARD TEACHING. (FS)

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RELATIONSHIP THERAPY AND/OR BEHAVIOR THERAPY?*

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Leonard Krasner begins his review in Contemporary Psychology (1966, 11, 341-344) of Eysenck and Rachman's "The Causes and Cures of Neurosis" with the statement: "A quiet yet dramatic revolution is underway in the field of psychotherapy." Krumboltz (1966c) entitled the proceedings of the Cubberly Conference on "Revolution in Counseling." A quiet revolution seems to me to be a contradiction in terms. The current development of behavior therapy, I would like to suggest, is neither quiet nor a revolution. The behavior therapists are far from being quiet. They are highly vociferous, dominating our professional journals with their cases and claims, exhibiting all the characteristics of a school or cult which they sail against. Rather than being a revolution, behavior therapy is a revival, a rediscovery of the story of Peter and the Rabbit first told by Mary Cover Jones (1924) under the tutelage of Watson. Once before behavior modification was going to save the world, through the practice of conditioning in the home and the nursery school. It might be instructive to study the reasons for its eclipse. One reason might be that parents could not maintain the objectivity required for the proper dispensation of rewards and punishments, but I suspect there were others, such as the limitations and limited effectiveness of the method. It might be well to temper current enthusiasm for behavior therapy by a look at the history of all new terapies. Many, if not most, of them appear to be highly successful at first, when they are used by enthusiastic believers, but then are found to be less effective, or noneffective, after the enthusiasm wanes. Faith, or the so-called placebo effect, may have more to do with the success of the behaviorists than the techniques themselves. But more will be said about this later.

There is more than one way to change behavior. Two such ways are through various conditioning procedures, and through the more usual methods of psychotherapy, including client-centered therapy. The question of which method to use in particular instances hinges upon a number of factors, such as the nature of the change desired, the condition of the client patient or subject whose behavior it is desired to change, and the implications of the change in terms of concomitmant changes or side effects. Efficiency is only one, and sometimes a minor factor, though it would appear to be the major factor to many behavior therapists. But if change could be obtained either through conditioning or through client-centered therapy, even though the specific change desired might be more easily and quickly changed through conditioning, it might be preferable to seek the change through client-centered therapy. It might be argued, with some justification, I think, that change occurring by the latter method might have certain advantages, at least in terms of certain values held and long-term effects desired by many counselors and others. These effects might include more active participation of the client in the change, the assuming of more responsibility by the client for the change with increasing learning of taking responsibility for himself, a greater sense of satisfaction and of achievement when the change has occurred in this way, greater independence and confidence in himself, perhaps a greater generalization and persistence of change or even greater induced change in other behaviors or total functioning or well-being.

In accordance with our plan for this program, I will begin with a brief statement of the client-centered approach to counseling or psychotherapy or, to use a more general term, relationship therapy. Then, following Dr. Krumboltz's presentation of behavioral counseling, I will make some comments on the similarities and differences of these two approaches.

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Some may wonder why it is necessary to describe client-centered counseling since it is now 25 years since the publication of its first statement by Rogers. Yet I find that few students, and not too many counselor educators, have a real understanding of it. There are some widely prevalent and persistent misunderstandings about or misconceptions of client-centered counseling. This necessitates some attention to what client-centered counseling is not.

Client-centered therapy is not nondirective. The term nondirective was formally abandoned with Rogers' 1951 book. Yet one still hears reference to nondirective counseling. Those who still use this term indicate how obsolete is their knowledge of client-centered counseling. Client-centered counseling is not nondirective in the sense that it has no objectives or goals, or that it accepts any and all goals of the client, or that the counselor does not structure or impose goals on the client. Client-centered therapy is not completely permissive. There are limits to what the client is permitted to do, or even to say.

Secondly, client-centered therapy is not simply the parroting of the words of the client, mirroring his statements, reflecting the words and content of his verbalizations. This is a common parody of client-centered therapy, represented by a story which originated almost 20 years ago. (Story)

Third, the client-centered therapist is not a passive, inactive individual, emitting an uh uh occasionally. Client-centered counseling is not, as some have designated it, the grunt-and-groan approach to therapy. This is a widely held misconception which has been involved in many research studies purporting to study client-centered counseling. A number of studies purport to show that clients do not like client-centered counseling. What they actually demonstrate is that clients do not like counselors who, not understanding or accepting client-centered counseling, are passive, inactive, unresponsive, and wooden in their relationships with the client. Clients would not be normal if they did not dislike such treatment.

Fourth, and perhaps summarizing the three points already made, client-centered counseling is not a simple, easily acquired set of techniques, applicable to, or limited to, clients with simple problems. Too often it is conceived by students as an approach which can easily be acquired without any study or practice and since it is not much good anyway, why bother with it.

These misconceptions of client-centered counseling are perpetuated by instructors in undergraduate psychology who belittle it, as well as by many counselor educators at the graduate level who claim to be client-centered.

It is possible that there was some basis for these misconceptions in the early development of client-centered counseling. There have, of course, been changes over the years. However, contrary to some impressions, there have been no essential changes in the basic assumptions and principles, but rather in their implementations, as the approach has been applied to more kinds of clients, including the hospitalized emotionally disturbed. There has been a movement toward more activity on the part of the therapist, toward use of a wider variety of techniques or kinds of responses by the counselor, toward less emphasis on techniques and increasing emphasis on the attitudes of the therapist. These changes have perhaps brought client-centered counseling closer to some other approaches, such as psychoanalysis or particularly some existential approaches. One client-centered writer (Hart, 1960) has suggested that there have been three stages in the development of the approach, the first indicated by the designation nondirective, the second by the term client-centered and the third, or current phrase which he suggests might be designated as experiential therapy.

In my analysis of theories or points of view in counseling andpsychotherapy (1966) I have classified client-centered therapy as an affective or relationship therapy, as distinguished from more rational approaches. The nature of this relationship, as offered by the therapist, is characterized by three conditions, which, from the standpoint of the therapist, may be considered to be the necessary and sufficient conditions of client-centered therapy, if not of all therapy.

The first condition is empathic understanding, the sharing of the client's inner world. The client-centered therapist strives to become sensitive to the feelings of the client, to accurately understand them and to convey this understanding to the client. This requires more than reflection of content, even more than simple reflection of feeling. This highly sensitive feeling with the client produces counselor responses which, to one who is lacking in sensitivity, would appear to be interpretation. But the purpose is different, i.e., to communicate understanding, not to create insight.

A second condition of client-centered therapy is what is known as unconditional positive regard. This means that the therapist accepts the client as a person of worth regardless of his behavior. It has been described as a nonpossessive warmth or caring for the client, or a "prizing" of him, without seeking to abrogate his right of self-determination. It is likely that accurate empathy cannot be achieved without the presence of unconditional positive regard.

The third condition is the presence of self-congruence, or transparency, in the therapist, during the therapy relationship. Self-congruence means that the therapist is integrated in the relationship, that he is genuine, not feeling or thinking one thing and saying another, that he is a real person, not playing a role, or presenting a facade. Self-congruence is the same as or similar to the openness frequently referred to in the recent literature on psychotherapy, or of the authenticity of the existentialist.

Two other conditions have been suggested by Truax and Carkhuff. One of these (Truax and Carkhuff, 1963) is high therapist intensity and intimacy in the therapeutic encounter. This can probably be included as part of the third condition or as implicit in the three conditions taken together. The other condition Truax and Carkhuff (1964 a, b) refer to as concreteness.

These conditions are not limited to client-centered therapy, of course; many other approaches include emphasis on one or more of them. But the client-centered view holds that they are the necessary and sufficient conditions of psychotherapy. While interpretive therapies emphasize the importance of empathic understanding as a basis for interpretations, client-centered therapy emphasizes its importance in itself.

Given the presence of these conditions in the therapist, the individual who qualifies as a client is enabled to disclose himself, to explore his feelings, attitudes, beliefs, values, perceptions of others and his hopes and fears or expectations and his relationships with others. If the counselor provides these conditions, and if they are communicated to or perceived by the client, then a relationship develops which is experienced by the client as safe, secure, free from threat, trustworthy, consistent. External threat is minimized so that the client can be less defensive, more open, and more transparent. This is a relationship making possible self-disclosure and the intrapersonal exploration which leads to constructive personality and behavior change.

The association of the three therapist conditions to client exploration and the relationship of client exploration to client change on a variety of criteria, have been demonstrated by a number of studies conducted by Rogers and his associates at Wisconsin. These conditions have been known to be effective, that is, related to therapeutic personality change.

I have suggested that these conditions are not unique to or limited to client-centered therapists. They are, in my opinion, present in all effective therapists, whatever else may be there in addition. They are also, in my opinion, the common aspects of all effective therapies. The important fact that therapeutic personality change occurs in the presence of these conditions, without any of the many other conditions present in other approaches to psychotherpay, is evidence that they are the sufficient conditions for effective psychotherapy. There is also considerable evidence that these conditions are effective in changing behavior, or fostering favorable personality development in other situation in addition to psychotherapy. These situations include the family or child rearing, schools, industry, and mental hospitals. The effects of environmental treatment in the form of the therapeutic mileau in mental hospitals seems to come from relationships between the staff and patients which are characterized by these conditions. They are in effect the conditions or principles of good human relationships in general, as suggested by Fielder's studies 15 years ago.

If these conditions are sufficient as well as necessary, then it must be shown that therapeutic personality change not only occurs when they are present, but that it does not occur when they are absent. It can, of course, be demonstrated that changes in behavior can be obtained when they are not present, as in simple conditioning, which may not involve the presence of another person, or in instances of coercion by the use of threat or physical force, including punishment. But it can be questioned whether such changes are therapeutic or that they persist when the reinforcement, coercion, or threat are removed.

There is some evidence from research on psychotherapy that in the absence of these conditions in psychotherapy positive change does not occur. Truax and Carkhuff (1963) found that while the (schizophrenic) patients of therapists evidencing high conditions of accurate empathy, unconditional positive regard and self-congruence improved, patients of therapists evidencing low levels of these conditions showed negative personality change. Similar results have been found with clients in college counseling centers, according to Truax. There also appears to be considerable evidence that the absence of these conditions in other situations leads to psychological disturbance. This evidence includes studies on the influence of schizophrenogenic mothers, the effects of the double bind, the effects of an institutional environment lacking in human attention on infants and children, the results of sensory isolation, and the effects of imprisonment.

There seems to be evidence that the elements of the therapeutic relationship which have been described are common to all approaches to psychotherapy and that where they are absent positive change or development does not occur. There thus appears to be a basis for considering them the necessary and sufficient conditions for psychotherapeutic change, as well as the essentials of client-centered therapy.

I have made the claim, and referred to the evidence for it, that client-centered or relationship therapy is effective. But it is also claimed that behavior therapy is effective. I would agree that this is so, although I do not believe the behavior therapists have demonstrated this by any acceptable research

as yet. So far, there are no adequately controlled studies. Reports of individual cases abound, but the behaviorists do not accept this as evidence for the effectiveness of any other approach. Nor would they accept from others the evidence Wolpe presents for his effectiveness, which consists of his own ratings or evaluations of selected cases.

But accepting the effectiveness of these two apparently quite different approaches to counseling or psychotherapy, there are two questions which must be considered. First, are the results achieved by both methods the same or similar? Do they have the same goals? Second, are these approaches really different? Do they have nothing in common? Are there really two (or more) basically different methods of changing behavior in a counseling or therapy situation, that is, the changing of significant behavior above the reflex level, where a change is voluntarily desired or sought by the subject, or client?

The goals of counseling have been variously stated to include such things as self-acceptance, self-understanding, insight, self-actualization, self-enhancement, adjustment, maturity, independence, responsibility, the solving of a specific problem or the making of a specific choice, learning how to solve problems or to make decisions, and the elimination of or the performance of specified acts or behaviors. Some, usually those who state the more general goals at the beginning of the list, feel that the goals of counseling should be the same for all clients. Ohters, including the behaviorists (Krumboltz, 1966, a,b,d), believe that goals should be specific for each client. The behaviorists see general goals as vague, indefinable, unmeasurable and neglecting individual differences. Some would see many of the specific goals of the behaviorists as trivial, partial, limited in significance or meaning, selected mainly because they are concrete and measurable, as by increasing frequency of performance of a specific act. The behaviorists may seem to be unconcerned about the meanings of their goals, or with any general criterion for determining the desirability of specific goals.

Can any agreement between these two points of view be achieved? I believe that it can be. As a matter of fact, the criteria actually used in studies of the effectiveness of client-centered therapy are specific. They include responses on the Rorschach, the MMPI, the TAT, the Wechsler Adult Intelligence Scale, Q sorts, and other tests and rating scales, including ratings of clients or patients by others. The significance of test responses in terms of other behavior may, of course, be questioned. A question may also be raised about the relationship of these measures to the general goals expressed by client-centered therapists. There have been some attempts to utilize or develop instruments related to these goals, however, such as Q sorts, the Personal Orientation Inventory (Shostrom, 1963) and the Problem Expression Scale (van der Veen & Tomlinson, 1962).

The behaviorists, on the other hand, do seem to be concerned with broader, more general goals or outcomes--greater freedom, more expressiveness, the more effective use of potentials--or self-actualization. But because they cannot count or measure these goals, they do not talk about them.

There need be no inconsistency between specific, immediate goals and more general, long-term goals. In fact, there should be a relationship or consistency. Specific goals may be, or should be, steps toward, or aspects of, a more general goal. Those who advocate the more general goals might accept some of the specific goals of the behaviorists. The behaviorists might accept a general goal if it could be specified how its attainment could be demonstrated.

A general goal such as that represented by the concept of self-actualization can serve as a criterion for the acceptance or desirability of more specific behaviors. Highly specific actions or behaviors have meaning only in a context, as part of the individual's total life, and when seen in relationship to a general goal or objective for life. Self-actualization may be considered as the goal or purpose of life, or, from another point of view, as the unitary motivation of all behavior (Goldstein, 1949, Patterson, 1964).

There is no reason why self-actualization cannot be defined, its characteristics or manifestations described, and instruments developed to measure its attainment. Maslow's (1956) study of self-actualizing persons is relevant here, since it attempts to define and describe the manifestations of self-actualization. Rogers (1959, 1961) specifications of the fully-functioning person is also relevant as a step in this direction.

The acceptance of a general goal for all clients does not mean that individual differences are ignored. Different individuals actualize themselves in different ways, that is the means of self-actualization vary among individuals, and at different times, allowing for different immediate goals, all of which are in effect subgoals. This, of course, complicates the evaluation of the attainment of the goal of self-actualization--or progress toward it, since it is probably never completely attained. But this is no more complex than the determining of specific goals and the criteria for their attainment which the behaviorists advocate. The point is that it seems desirable to have some criterion to apply in the selection of specific, limited goals. These specific behaviors are aspects of a total individual, a person, who is more than a bundle of separate behaviors established through mechanical reinforcements. It is probably the case at present that, while the client-centered counselors are interested in goals that are too general or vague, at least in terms of present ability to define and measure them, the behaviorists seem to be too specific, lacking in any general theory or criterion for selecting their goals.

If, as I think is possible, we can gain some agreement on goals, both general and specific, are these goals attainable by widely differing means? Or are client-centered therapy and behavior therapy essentially the same?

The essence of the client-centered approach is a relationship, with the characteristics described earlier. It is a complex relationship, with various aspects. It is not simply a cognitive, intellectual, impersonal relationship, but an affective, experiential, highly personal relationship. It is not necessarily irrational, but it has nonrational aspects. Evidence seems to be accumulating that the effective element in counseling or psychotherapy is the relationship. Goldstein (1962, p. 105), after reviewing the literature on therapist-patient expectancies in psychotherapy, concluded: "There can no longer be any doubt as to the primary status which must be accorded the therapeutic relationship in the over-all therapeutic transaction."

Now the behavior therapists appear to be unconcerned about the relationship, or perhaps it would be more accurate to say that they minimize its importance, treating it as a general rather than a specific condition for therapy. Wolpe (1958) recognizes it as a common element in therapy, but not a sufficient condition for change in most cases. He does recognize its effectiveness in some cases, however, when he notes: "I have a strong clinical impression that patients who display strong positive emotions toward me during the early interviews are particularly likely to show improvement <u>before</u> special methods for obtaining

reciprocal inhibition of anxiety are applied" (Wolpe, 1958, p. 194). Krumboltz (1966d) also recognizes the relationship as a necessary but not sufficient condition.

Examination of the functioning of behavior therapists such as Wolpe, makes it very clear that the behavior therapist is highly interested in, concerned about, and devoted to helping the client. He is genuine open, and congruent. He is understanding, and empathic, though perhaps not always to a high degree. He respects his client, though he may not rate extremely high on unconditional positive regard. There is no question but that a strong relationship is present. Behavior therapists are human, they are nice people, not machines (refer to Ogden Lindsley, Ullmann, Krumboltz).

Now I would like to suggest that the relationship is not only a necessary but the sufficient condition for therapeutic personality change. Wolpe concedes that it is in some cases. I suggest that it is in all cases. Let me try to indicate why this is so.

I noted earlier that the relationship is complex. It almost certainly includes more significant aspects than the three mentioned earlier although these themselves are complex. Some of the other aspects can be mentioned. Every therapy relationship is characterized by a belief on the part of the therapist in the possibility of client change, by an expectation that the client will change, by a desire to help, influence or change him, and, highly important, confidence in the approach or method which is used to achieve change. The client, for his part, also contributes to the relationship. He needs and wants help, recognizes this need, believes that he can change, believes that the counselor or therapist, with his methods, can help him change, and finally he puts forth some effort or engages in some activity in the attempt to change. These characteristics are all present in behavior therapy. Their presence alone produces change; they include most of what has been referred to as the placebo effect. One might say, with good evidence to support such a statement, that it almost does not matter what specific behavior the therapist engages in as long as these conditions are present.

The consideration of the nature and importance of the relationship leads to the necessity for caution in accepting the claims of the behavior therapists that their results are due to their specific techniques rather than to the relationship, or that their results are greater than could be achieved by means of the relationship alone. One aspect of this is the well-known fact that any new approach, applied with enthusiasm and confidence, and accompanied by faith in its efficacy on the part of the therapist and the client, is always successful when first applied, and continues to be successful to some extent as long as the confidence and faith in it continue. A second implication of the known power of the relationship is that in order to demonstrate the efficacy of the specific techniques of behavior therapy, their effects must be tested apart from or independent of the relationship. As a matter of fact, these techniques have been tested in the laboratory although not entirely apart from the influence of the relationship between the subject and the experimenter, as Orne (1962) points out in his discussion of the social psychology of the psychological experiment. (The work of Rosenthal /1964, 1966/ on the effect of the experimenter on the results of psychological research is relevant here also). The results of such research, that is, laboratory research on conditioning, indicate that (a) generalization is difficult to obtain and (b) in every or situation (with one possible exception which cannot be considered here), when the reinforcement is discontinued, the conditioned behavior ceases, or is extinguished. If this is the case, why does the behavior conditioned in behavior therapy persist? Either there are other factors operating, or the reinforcement is continued outside of therapy. If the latter is the case, what is the nature of this reinforcement?

Perhaps it is too stringent a requirement to insist that behavior therapists eliminate the relationship to demonstrate the effectiveness of their specific methods. After all, they do recognize that the relationship is necessary. But at least they ought to control the relationship; they ought to test the added effects due to their specific methods, instead of simply stating that since other methods emphasizing the relationship achieve only about 60 percent success, and since they achieve (so they claim) 90 percent success, the difference is due to their specific methods. This is obviously unacceptable evidence, for several reasons which cannot be enumerated here.

The laboratory research on conditioning itself demonstrates the importance of the relationship between the experimenter and the subject for obtaining conditioning. The development of conditioning, the rate of conditioning, and the extent and persistence of conditioning are related to and influenced by the personality and attitudes of the experimenter and his relationship to the subject (Ullmann and Krasner, 1965, p. 43). The essential point is that the relationship is more important than the behavior therapists recognize, and their claims that the effects they produce are greater than those which can be attributed to the relationship alone have not been demonstrated.

But there is another aspect of the counseling relationship, an inherent element in the relationship, which must be recognized. Simply stated the counseling relationship (and every good human relationship) is reinforcing. Reinforcement, and conditioning, are an inherent part of the therapeutic relationship. It is by now generally recognized that all therapists reinforce, by one means or another, the production of the kinds of verbalization in their clients in which they are interested, i.e., the kind they feel are therapeutic, whether it is talk of sex, inferiority feelings, self-concepts or of decision making. The therapist rewards the appropriate verbalizations by his interest, his attention, or by implicit or explicit indications of praise or approval.

The therapeutic relationship also, as a number of writers, including Shoben (1949) and Dollard & Miller (1950) have noted, provides, by its accepting, understanding, nonthreatening atmosphere, a situation where anxiety may be extinguished. Further than this, I would like to suggest that, in such a relationship, where external threat is minimized, desensitization occurs. Anxiety arousing thoughts, ideas, images, words and feelings are free to appear. Moreover, I believe that they appear in a hierarchial sequence which is the same as that laboriously established by Wolpe (1958), that is, from the least anxiety arousing to the more anxiety arousing. Thus, in any good (nonthreatening) therapy relationship, desensitization occurs in the manner produced by Wolpe. The relationship, by minimizing externally induced anxiety, makes it possible for the client to experience and bring out his internally induced anxieties, or anxiety arousing experiences, at the time and rate at which he can face and handle them in the accepting relationship. Ullmann and Krasner (1965, p. 37) state that the behavior therapists are systematic in their application of specific learning concepts. But it might also be said that client-centered or relationship therapists are systematic in the application of these principles, though not in the same conscious or deliberate manner.

We might conclude that there are not two different kinds of therapy, relationship therapy and behavior therapy. All counseling or psychotherapy involves both a relationship and conditioning. The difference between relationship therapy

and behavior therapy is essentially one of emphasis. The behavior therapist emphasizes conditioning techniques, which he applies systematically, and is not systematic in his development of a relationship. The relationship therapist systematically develops a relationship, but is not so consciously systematic in applying conditioning techniques. Which is better? Or should both the relationship and the conditioning techniques be used systematically? The behavior therapist, by providing a relationship, unsystematically treats other, perhaps underlying or more general problems than the specific ones he focuses upon with his particular techniques. The relationship therapist, on the other hand, influences more specific behaviors by his reinforcement of client behavior. There are a number of aspects of these questions which warrant some comment.

It may be that for some kinds of problems or goals, emphasis upon techniques, as part of a relationship, is more effective. These problems and goals are perhaps those that the behavior therapists seem to be interested in. It would seem reasonable to believe that, where we are concerned with specific behaviors, representing inadequate learning or resulting from absence of or inadequate education or training, we apply methods of training or relearning which are most effective. For example, where a particular kind of behavior is desired, or required, we apply the most effective reward when such behavior is performed, and continue this reinforcement until the behavior is "learned" to a desired criterion, or until the client receives reinforcement by others in his life to assure its continuance.

But for different kinds of behavior or goals, we should seek for the most potent reinforcers. It is suggested that for some kinds of behavior the most potent reinforcement is a good human relationship. Some, if not many, clients, are not seeking to change specific behaviors, but to develop different attitudes and feelings toward themselves and others, to find a meaning in life, to develop long-term or life goals to determine who and what they are, to develop a self-concept. The behaviorist would presumably attempt to reduce these goals or desires of clients to specific behaviors, or perhaps decide that such clients were not appropriate for them, or even not in need of counseling. But the attempt to reduce such concerns or problems to specifics may lead to breaking up the total person, to dealing with specific aspects of behavior which may not be particularly relevant to the client as a whole. It appears that some behavior therapists, if one may judge from their approach, refuse to accept any client statement of a problem which is not a specific one with which they can deal. It is interesting in this respect to note that Wolpe does in his demonstration tape (Wolpe, 1965). He refuses to accept any problems presented by the client, but defines her problem in his own terms. Behavior therapists, if not always overtly forcing the client to accept their definition of his problem, perhaps teach or condition their clients to have the kinds of problems of which their techniques are applicable.

Moreover, some behaviors <u>are</u> symptoms--not necessarily symptoms of a presumed underlying pathology in a medical sense, but indications of more widespread problem or disturbance. The client may not be able to express this. The presenting problem is not always the real or total problem. The behavior therapists seem to deny or refuse to accept any problem which is not concrete or specific. London (1964) notes that the behavior therapist must "drastically curtail the range of persons or problems he attacks. Courting specificity /he/ risks wedding triviality." If he widens the concept of "symptom," until it includes meaning, his position becomes scientifically tenuous, according to London. One might ask the behavior therapist how he would decondition the pain or suffering of the client who suffers from a realization that he is not functioning up to his potential or

aspiration level, who has a concept of himself as a failure, or who experiences a lack of meaning in his life. I am not convinced that the specific behaviors which might be derived from such complaints by a behaviorist would actually represent or include the problem. And if the behaviorist would deny that such complaints are real problems, then he would seem to be taking the narrow behaviorist position that nothing exists which cannot be dealt with by his specific techniques.

The specificity and concreteness of the behaviorist, as it appears to be represented in those concerned with clients in an educational setting, such as Krumboltz, seems to me to be moving from counseling or psychotherapy toward teaching. There seems to be some confusion about what is counseling and what is teaching. (Parenthetically, it is interesting that those who most strongly insist that there is a difference between counseling and psychotherapy tend not to distinguish between counseling and teaching.) Much emphasis has been placed upon the similarity between counseling and teaching, illustrated by the statement that counseling is deeper teaching, or that counseling or psychotherapy is learning. To counteract this tendency to identify teaching and counseling, I have sometimes suggested that the greatest similarity may be that both utilize a 50-minute hour. There are, of course, similarities, and as in many other situations, the major difference may be one of emphasis. It would appear to me that the emphasis in teaching is upon cognitive problems or aspects of behavior, while the emphasis on counseling is--or should be--upon affective problems or aspects of behavior.

But the behavior counselors seem to be involved more with teaching, on an individual basis, than with counseling, and, for the more cognitively oriented kinds of problems with which they deal, perhaps the methods of behavior therapy are more applicable. Let me point out, however, that, as Krumboltz (1966d) notes, classical conditioning is important in emotional learning. But most of Krumboltz's concern is with operant conditioning, imitative learning and cognitive learning, and the concerns of the Cubberley Conference on which he was reporting included "procedures for encouraging college accomplishment among disadvantaged youth, minimizing classroom learning and discipline problems, developing decision-making ability, modifying the behavior of autistic children, reducing test anxiety, building an environment conducive to school achievement, increasing attentive behavior, encouraging career exploration, improving testwiseness, improving child-rearing techniques, using computers in counseling, increasing the assertive behavior of shy children, and improving study habits" (Krumboltz, 1966c, p. VIII). These are concerns, and things concerning which the learning techniques of behavior modification have much to contribute, but, I wonder, how many of these problems and their treatment would be considered as involving counseling? In this conference also, Bijou (1966) presents an excellent paper which is entitled "Implications of behavioral science for counseling and guidance," but which has nothing to do with counseling, but rather with the modification of the environment to shape the behavior of children.

The broad goals desired by the relationship therapists are perhaps those most consistent with the emphasis upon the therapeutic relationship. This relationship, as described earlier, would appear to lead to behavior, in the interview, and probably outside, though this has not been adequately demonstrated, which is related to the general goals listed earlier, including such things as independence, and taking responsibility for onself. One outcome in the interview of a relationship characterized by empathic understanding, therapist genuineness and congruence and unconditional positive regard has been demonstrated (Truax and Carkhuff, 1964). This is intrapersonal exploration, the exploration by the

client of his attitudes, feelings, values, perceptions, relationships, choices, etc. Empathic understanding, unconditional positive regard, and therapist genuineness are, in other words, reinforcers of client self-exploration. And intrapersonal exploration has in turn been related to positive outcomes of counseling.

This approach, it seems to me, has several advantages. (1) It does not restrict counseling to one or a few specific problems determined by the client or the client and therapist early in the counseling process. (2) It does not attempt to deal with specific problems independently of each other, but deals with the total person of the client. (3) The nonthreatening atmosphere created not only makes possible client self-exploration, but also the desensitization and anxiety extinction accomplished in behavior therapy. (4) It places more responsibility on the client for the process of therapy, thus reinforcing independence and responsibility. (5) Its goals of self-exploration, responsibility and independence, outside of and following therapy as well as within therapy, allow the client maximum freedom in making choices and decisions regarding specific goals or behavior changes. (6) Insofar as self-exploration, independence and responsibility are aspects of, or lead to self-actualization, this ultimate goal is promoted.

Fundamentally, therefore, I am a behaviorist, at least in the sense that I recognize and accept the existence of reinforcement and conditioning. But behavior is broader than motor acts or physical activity. It includes thoughts and feelings, attitudes toward and relationships with others, values and meanings held by and verbalized, internally or externally, by the individual, and I think we need to scrutinize carefully just what we want to reinforce in people, as well as the kinds of reinforcement which are appropriate, or most effective, for different outcomes. I am not here emphasizing the ethical and value problems posed by the possibility of controlling behavior, since I have done this elsewhere, although values certainly are involved in decisions about what kinds of behavior one selects for reinforcement. But specific behaviors must be considered in terms of the perspective of their meaning for life; they may be considered as means to the end of living a meaningful life, of actualizing one's potentialities as much as possible.

The question is not one of whether we should accept behavior therapy or become behavior therapists. As it is frequently said that all therapists are client-centered, so all therapists are behavior therapists.

For the individual counselor, however, there are alternatives, in what clients he works with or what kinds of problems he accepts to work with, and the way in which he works with clients. He can choose to deal with clients with specific problems or kinds of behavior which the client and counselor agree should be changed, and apply specific conditioning techniques to achieve these changes. Or he can choose to select and work with clients who express broader, more general problems and desire an opportunity to explore feelings and attitudes about these problems, and consider values, goals and objectives for their lives, in which case he will offer the kind of relationship which appears to help the client explore himself. It may be, as the behavior therapist seems to believe, that the majority of clients have specific problems and desire to eliminate or to develop specific behaviors. Personally, I doubt this. I believe there are many clients who want to experience a relationship, to be accepted and understood, to be allowed to explore themselves in order to find themselves. One's theory and method, of course, affect one's perceptions, and there is also selection of clients, and of counselors

by clients based on knowledge of the methods, and the reputation of the counselor. Clients have been known to present the problems which the counselor likes or prefers to deal with.

Nor should there be any need for relationship therapists to feel, as many are being made to feel by some of the statements and claims of the behavior therapists, that relationship therapy is not effective, is no longer respectable, is nonscientific, and obsolete. One might take the stand that behavior therapy is limited as in a strict sense it is if the basic therapeutic relationship is not present, that it is not applicable to the major problems of modern man, as a person rather than a biological organism.

Personally, I prefer to avoid restricted agreements with clients about specific limited goals or objectives. In my opinion the treatment of many of the specific problems with which behavior therapists are concerned is teaching, much of which can be performed by a technician. Some of these problems might be considered analogous to a wart, as compared to a brain tumor. The removal of a wart may be important, and may have implications of one's self-concept. But in general a brain tumor is of more significance to the individual. I am willing to leave the removal of warts to others, and would prefer to devote my time to the client who wants to consider what he should do with his life.

This analogy, of course, may be questioned. The behavior therapists could probably find one which had opposite implications. My only point is that relationship therapists are not second-class professionals. The behavior therapists, in providing a good relationship as a basis for their special techniques, are human beings. The relationship therapists, providing conditions which have been demonstrated to produce therapeutic behavior change, are in just as good standing scientifically as the behavior therapists.

The application of behavior modification techniques is not likely to be the cure all that some enthusiasts seem to imply. Monkeys can be taught, by conditioning, to do many things--such as picking olives. These and other employable skills can no doubt be taught to socially and economically disadvantaged and chronically unemployed humans. But there is a question as to whether this is sufficient, even if we accept it as desirable, if we are concerned with them as people and potential full members of society rather than simply as workers. Sanford (Self and society, pp. 3-4), discussing the program of the women's Job Corps Centers, suggests that "...it seems likely that, in order to teach these girls the skills and social competencies that would make them employable, it would first be necessary to change attitudes, to develop different self-conceptions--indeed to undertake socialization on a broad scale...as a minimum it would be necessary to build up whatever was necessary in order for a girl to hold a job... such a girl would not be likely to hold a job unless she could see some point in it, and this would require that she develop in herself capacities for enjoying its benefits and taking satisfaction in it...." The residential centers, then, would have to be conceived as institutions for personality development." Now the behaviorists claim that by conditioning behaviors, such complex behavior can be built up. But the evidence for the claim is lacking.

Behavior therapists emphasize the efficiency of their methods, the small number of interviews required to achieve success with specific symptoms. This could be because they may be dealing with simple, isolated, restricted behavior disturbances. But there may be an even more efficient way of dealing with such behaviors. At a VA hospital one of the patients was irritating the staff by

sticking his tongue out at them. The staff was responding nontherapeutically. A student trainee decided to use aversive conditioning in the interview. After a few interviews the patient said: "Say, Doc, if you're trying to get me to stop sticking my tongue out, just say so and I'll stop." If we want clients or students to engage in certain specific behaviors, such as some techniques of problem solving, asking questions, exploring alternatives, perhaps the most efficient way is to ask them openly, or suggest it to them, or teach them in the usual way, rather than resort to lengthy conditioning procedures, which in effect may be a sort of guessing game in which the client has to find out what you want him to do. This is an indication of the confusion between counseling and teaching. Since the relationship is not so important in teaching, which is more cognitively oriented, it is understandable why behavior therapists consider the relationship as relatively unimportant.

The trend is toward taking the position that there are different forms of treatment for different conditions or clients. Ford & Urban, in their chapter in the 1967 Annual Review of Psychology play this theme: "differential problems require differential treatment" (p. 335). Referring to Angyal's unitary theory of neuroses, they write: "Such oversimplification of the problem seems anachronistic" (p. 336). They continue: "If the cause of all disorder is basically the same, it follows that one psychotherapeutic approach will suffice for all. The trend /they continue/ is clearly to reject this view. There is growing evidence that disorders may differ in the patterns of behavior which become involved, the antecedents which elicit these patterns, and the consequents to which they lead.... Such a view requires careful analyses of a person's response patterns to determine what is wrong and what circumstances contribute to the difficulty. It also opens the door to the possibility that a great variety of therapeutic procedures may be necessary." (p. 340). It is interesting that in a review article, no references are given for the evidence to which they refer. In commenting on the variety of techniques which the behavior therapists use, they note that "any position which espouses the use of a variety of therapeutic procedures for a variety of objectives is in need of a conception of psychopathology (or behavior disorders, if one does not like the disease connotation of the other term) with which to make differential diagnoses (or behavior evaluations) on which the selection of therapeutic procedures can be based" (p. 341). But they refer to no evidence of progress in this area of classification or differential diagnosis. Ford & Urban later refer approvingly to Hyman & Breger's comments on a paper by Eysenck in which they "argue that the question ' is psychotherapy effective?' is an inappropriate sort of question because it implies homogeneity of patient and treatment which does not in fact exist. Calling attention to the heterogeneity of theory, techniques, patients presenting problems, therapist proficiencies, treatment goals, and the like, they explicitly admonish those who would lump them together and treat them as if they were the same. On the contrary, a more effective set of questions would be cast in the form: Which set of procedures is effective for what set of purposes when applied to what kinds of patients with which sets of problems and practiced by which sort of therapists?" (p. 359) Admonish is the appropriate term--no good evidence can be presented in favor of this position. Indeed, this position, rather than its opposite, may be considered an anachronism, dating back to Thorne and others who were saying the same thing 25 years ago. The point of view has made little impression or practice. If one examines any theoretical approach to psychotherapy, one will find that every one of them--except purportedly behavior therapy, which is hardly a theoretically based approach--assess that there is a common cause of emotional disturbance and a single method of treatment. It might be maintained that the research evidence to date supports this position. The emphasis on heterogeneity of goals

and objectives, procedures, patients, problems, and therapists logically leads to the conclusion that each of the infinitely different combinations requires a different method and approach. So why the revival of the specificity emphasis? It is no doubt the influence of behavior therapy. But behavior therapy in fact accepts a unitary basis for all behavior disorder--lack of an inadequate learning--and a single treatment--the application of a particular learning approach.

References

Bijou, S. W., Implications of behavioral science for counseling and guidance. In Krumboltz, J. D. (Ed.) Revolution in counseling, Boston: Houghton Mifflin, 1966.

Dollard, J., & Miller, N. E., Personality and psychotherapy. New York: McGraw-Hill, 1950.

Goldstein, A. P., Therapist-patient expectancies in psychotherapy. New York: Macmillan, 1962.

Goldstein, K., The organism. New York: World Book, 1939.

Hart, J., The evolution of client-centered therapy. Unpublished paper, 1960.

Jones, Mary C., A laboratory study of fear: the case of Peter. Pedogogical Sem., 1924, 31, 308-315. Reprinted in Eysenck, H. J. (Ed.) Behavior therapy and the neuroses. New York: Pergamon Press, 1960.

Krasner, L., Review of Eysenck, H. J., & Rachmann, S., "The causes and cures of neurosis; an introduction to modern behavior therapy based on learning theory and the principles of conditioning." Contemp. Psychol., 1966, 11, 341-344.

Krumboltz, J. D., Behavioral goals for counseling. J. counsel. psychol., 1966, 13, 153-159 (a).

Krumboltz, J. D., Stating the goals of counseling. Monogr. No. 1, California and Guidance Assn., 1966 (b).

Krumboltz, J. D. (Ed.), Revolution in counseling. Boston: Houghton Mifflin, 1966 (c).

Krumboltz, J. D., Promoting adaptive behavior. In Krumboltz, J. D. (Ed.), Revolution in counsling. Boston: Houghton Mifflin, 1966 (d).

Maslow, A. H., Self-actualizing people: a study of psychological health. In Moustakas, C. E. (Ed.), The self: explorations in personal growth. New York: Harper and Row, 1956. Pp. 160-194.

Orne, M. T., On the psychology of the psychological experiment. Amer. Psychologist. 1962, 17, 776-783.

Patterson, C. H., A unitary theory of motivation and its counseling implications. J. indiv. psychol., 1964, 20, 17-31.

Patterson, C. H., Theories of counseling and psychotherapy. New York: Harper & Row, 1966.

Rogers, C. R., A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), Psychology: a study of a science. Study I. Conceptual and systematic. Vol. 3. Formulations of the person and the social context. New York: McGraw Hill, 1959. Pp. 184-256.

Rogers, C. R., The therapist's view of the good life: The fully-functioning person. In On becoming a person. Boston: Houghton Mifflin, 1901. Pp. 183-196.

Rosenthal, B., The effect of the experimenter on the results of psychological research. In Maher B. (Ed.), Progress in experimental research. Vol. I. New York: Academic Press 1964.

Rosenthal, B., Experimenter effects in behavioral research. New York: Appleton-Century-Crofts, 1966.

Shoben, E. J., Jr., Psychotherapy as a learning problem. Psychol. Bull., 1949, 46, 366-392.

Shostrom, E. L., The Personal Orientation Inventory. San Diego, Calif.: Educational and Industrial Testing Service, 1963.

Truax, C. B. & Carkhuff, R. R., Concreteness: a neglected variable in research in psychotherapy. J. clin. psychol., 1964, 20, 264-267 (a).

Truax, C. B. & Carkhuff, R. R., The old and the new: theory and research in counseling and psychotherapy. Personnel Guid. J., 1964, 42, 860-866 (b).

Wolpe, J., Psychotherapy by reciprocal inhibition. Stanford: Stanford University Press, 1958.

Wolpe, J., The case of Mrs. Schmidt. Typescript and record published by Counselor Recordings and Tests, Box 6184, Acklen Sta., Nashville, Tennessee, 1965.

Ullmann, L. P. & Krasner, L. (Ed), Case studies in behavior modification. New York: Holt, Rinehart & Winston, 1965.

Van der Veen, F. & Tomlinson, T. M., Problem Expression Scale, Madison, Wisconsin: Wisconsin Psychiatric Institute, University of Wisconsin, 1962.

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